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Report of the Working Group on the issue of discrimination against women in law and in practice

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Working Group on the issue of discrimination against women in law and in practice pursuant to Council resolutions 15/23 and 26/5. In its report, the Working Group addresses the issue of discrimination against women with regard to health and safety. The instrumentalization of women's bodies lies at the heart of discrimination against women, obstructing the achievement of their highest attainable standard of health. The Working Group highlights in particular the health and safety situation of women who experience discrimination on multiple and intersectional grounds. Women's non-discriminatory enjoyment of the right to health must be autonomous, effective and affordable and the State has the primary responsibility to respect, protect and fulfil women's right to health in law and in practice, including where health services are provided by private actors.

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Contents

		Page
I.	Introduction	3
II.	Activities	3
	A. Sessions	3
	B. Country visits	3
	C. Communications and press releases	4
	D. Other activities	4
III.	Thematic analysis: eliminating discrimination against women with regard to health and safety	4
	A. Conceptual framework	4
	B. Meaning of equality in women's health and safety	6
	C. Discriminatory practices	7
	D. Instrumentalization of women's bodies	12
	E. Autonomous, affordable and effective access to health care	16
IV.	Conclusions and recommendations	18
	A. General recommendations	19
	B. Equality and non-discrimination	19
	C. Instrumentalization of women's bodies	21
	D. Autonomous, affordable and effective access to health care	22

I. Introduction

1. The present report covers the activities of the Working Group on the issue of discrimination against women in law and in practice undertaken since the submission of its previous report (A/HRC/29/40) until March 2016. It focuses on an analysis by the Working Group of discrimination against women with regard to health and safety.

2. The roles of Chair-Rapporteur and Vice-Chair of the Working Group were carried out by Emna Aouij and Eleonora Zielinska, respectively, until June 2015, and at the time of writing are held by Eleonora Zielinska and Alda Facio, respectively.

II. Activities

A. Sessions

3. The Working Group held three sessions in Geneva during the period under review. At its thirteenth session (4-8 May 2015), it held consultations on women's health and safety, including their rights to reproductive and sexual health, with a number of stakeholders and experts, including representatives from the World Health Organization (WHO), the United Nations Population Fund, the United Nations Research Institute for Social Development , the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and civil society organizations as well as expert staff of the Office of the United Nations High Commissioner for Human Rights (OHCHR).

4. At its fourteenth session (12-16 October 2015), the Working Group continued its consultations on the issue of women's health and safety, including with experts from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Inter-Parliamentary Union, the Committee on Economic, Social and Cultural Rights, the secretariats of OHCHR treaty monitoring bodies, the Special Rapporteur on the rights of persons with disabilities and members of civil society organizations. The Working Group exchanged views with Member States on its work and held a meeting with the United Nations High Commissioner for Human Rights.

5. At its fifteenth session (25-29 January 2016), the Working Group held a meeting with the Permanent Representative of the Organization of Islamic Cooperation to the United Nations Office at Geneva. It began its consultation on the development of a compendium of good practices and held a briefing with civil society organizations.

B. Country visits

6. The Working Group visited Senegal from 7 to 17 April 2015 (A/HRC/32/44/Add.1) and the United States of America from 30 November to 11 December 2015 (A/HRC/32/44/Add.2). It wishes to thank the Governments of these countries for their cooperation before and during the visits. It thanks the Governments of Hungary and Kuwait for responding positively to requests for visits, which will take place from 17 to 27 May 2016 and from 6 to 15 December 2016, respectively.

C. Communications and press releases

7. During the period under review, the Working Group addressed communications to Governments, individually or jointly with other mandate holders. The communications concerned a wide range of subjects falling within its mandate, including discriminatory legislation and practices with regard to marital status, nationality, allegations of abuses of women human rights defenders and violations of their rights, gender-based violence and rights to reproductive and sexual health (see A/HRC/30/27, A/HRC/31/79 and A/HRC/32/53). The Working Group also issued press releases, individually or jointly with other mandate holders, treaty bodies and regional mechanisms.

D. Other activities

8. On 15 June 2015, a member of the Working Group participated in a panel discussion on making social policy work for women at a workshop titled "Substantive equality for women: connecting human rights and public policy" organized by the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the United Nations Institute for Social Development and OHCHR.

9. The Working Group, jointly with several special procedures, sent an open letter to the President of the Human Rights Council on 3 July 2015, in which it emphasized the importance of placing women's right to equality at the centre of discussions in the Council on the protection of the family.

10. A member of the Working Group participated as a panellist in an OHCHR global seminar on the human rights of migrant domestic workers in an irregular situation, titled "Behind closed doors", held on 28 and 29 September 2015 in Bangkok.

11. A member of the Working Group gave a presentation at the expert consultation on gender perspectives on torture and other cruel, inhuman or degrading treatment or punishment organized on 5 and 6 November 2015 by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.

III. Thematic analysis: eliminating discrimination against women with regard to health and safety[1]

A. Conceptual framework

12. The present report aims to clarify the meaning of equality in the area of health and safety, identify discriminatory practices, expose the instrumentalization of women's bodies in violation of their human dignity and reveal the barriers to women's autonomous, effective and affordable access to health care. Instrumentalization is defined as the subjection of women's natural biological functions to a politicized patriarchal agenda, which aims at maintaining and perpetrating certain ideas of femininity versus masculinity or of women's subordinate role in society.

[1] The analysis contained in the present report has a minimal number of footnotes owing to word limit restrictions. A version of the report with full references can be found at www.ohchr.org/EN/Issues/Women/WGWomen/Pages/WGWomenIndex.aspx. The report relies on WHO and UNAIDS sources for health data and draws upon the work of OHCHR and international human rights mechanisms, including the Committee on the Elimination of Discrimination against Women and the special procedures mandates on health, persons with disabilities, food, older persons, water and sanitation, and indigenous peoples.

13. Women's rights to equality and to the highest attainable standards of health, to enjoy the benefits of scientific progress and to health-care services, including those related to reproductive and sexual health, are enshrined in international and regional human rights instruments, reaffirmed in consensus agreements, including the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action adopted at the Fourth World Conference on Women and the outcome documents of the review and appraisal conferences, and recognized by international, regional and national mechanisms and jurisprudence. The International Conference on Population and Development, held in 1994, recognized women's rights to reproductive and sexual health as being key to women's health. Discrimination against women in the area of health and safety and denial of their right to control their own bodies severely violate their human dignity, which, along with equality, is recognized in the Universal Declaration of Human Rights as the foundation of freedom, justice and peace in the world.

14. States are obliged to secure women's rights to the highest attainable standard of health and safety, including their underlying determinants, and women's equal access to health-care services, including those related to family planning, as well as their rights to privacy, information and bodily integrity. The obligation to respect, protect and fulfil women's right to equal access to health-care services and to eliminate all forms of discrimination against women with regard to their health and safety is violated by neglecting women's health needs, failing to make gender-sensitive health interventions, depriving women of autonomous decision-making capacity and criminalizing or denying them access to health services that only women require. In some situations, failure to protect women's rights to health and safety may amount to cruel, inhuman or degrading treatment or punishment or torture, or even a violation of their right to life.

15. WHO defines health as not merely the absence of disease or infirmity, but as a state of complete physical, mental and social well-being. In the present report the Working Group addresses women's safety as an integral aspect of their health. Women's exposure to gender-based violence in both the public and private spheres, including in conflict situations, is a major component of women's physical and mental ill health and the destruction of their well-being, and constitutes a violation of their human rights.

16. Substantive equality in the area of health and safety requires differential treatment. Throughout their life cycle from childhood to old age, women have health needs and vulnerabilities that are distinctively different from those of men. Women have specific biological functions, are exposed to health problems that affect only women, are victims of pervasive gender-based violence and, statistically speaking, live longer than men, resulting in their greater need to access health services frequently and into older age. Hence, women and girls experience the negative effects of insufficiencies in health-care services more intensively than men.

17. Women face a disproportionate risk of being subjected to humiliating and degrading treatment in health-care facilities, especially during pregnancy, childbirth and the post-partum period. Furthermore, they are especially vulnerable to degrading treatment in situations where they are deprived of liberty, including in migrant detention facilities or mental institutions. They are subjected to humiliating treatment within the health-care system because of their gender identity and sexual orientation, sometimes expressly in the name of morality or religion, as a way of punishing what is considered "immoral" behaviour.

18. Women's bodies are instrumentalized for cultural, political and economic purposes rooted in patriarchal traditions. Instrumentalization occurs within and beyond the health sector and is deeply embedded in multiple forms of social and political control over women. It aims at perpetuating taboos and stigmas concerning women's bodies and their traditional roles in society, especially in relation to their sexuality and to reproduction. As a

result, women face continuous challenges in accessing health care and in maintaining autonomous control in decision-making about their own bodies. Understanding and eliminating the instrumentalization of women's bodies, which is based on harmful cultural norms and stereotypes, and its detrimental impact on women's health, is critical for change to occur.

19. A wide range of actors, both public and private, play a role that affects women's health and access to health care and each of the actors bears responsibility for its actions or inactions. In particular, the significant role of the principles enshrined in the deontological codes of different medical professionals and in the rules governing the corporate social responsibility of the pharmaceutical industry are an essential locus for establishing gender-sensitive research, medicines and treatments.

20. The State is accountable for fulfilling its international human rights obligation to ensure that women are provided with gender-responsive scientific research, medicines and health interventions and for providing appropriate and adequate gender-based resources and a system of effective monitoring, budgeting, remedies and redress. It is also obligated to provide women with autonomous, effective and affordable access to health care. The State has a responsibility to ensure that barriers to women's enjoyment of the right to the highest attainable standard of physical and mental health are dismantled, including by exercising due diligence.

21. A number of other factors and developments which have serious implications for women's health and safety are not tackled in the present report owing to space restrictions. These include climate change and other environmental catastrophes and degradation and gender-based violence in armed conflicts.

B. Meaning of equality in women's health and safety

22. In the area of health, the distinctly different biological and reproductive functions of women and men necessitate differential treatment and proper algorithms are required to make sure that women have equal access to and enjoy the highest achievable level of health treatment. An identical approach to treatment, medication, budgeting and accessibility would in fact constitute discrimination.

23. Central among women's and girls' health needs are those relating to their reproductive and sexual health. Substantive equality requires that States attend to the risk factors that predominantly affect women. For instance, since only women can become pregnant, a lack of access to contraceptives is bound to affect their health disproportionately. Equality in reproductive health requires access, without discrimination, to affordable, quality contraception; maternal health care, including during childbirth and the post-partum period; access to safe termination of pregnancy; access to effective screening and early treatment for breast and cervical cancer; and special attention to the high rate of HIV infections among young women and treatment to prevent mother-to-infant transmission.

24. Equality also requires health policy to be based solely on women's health needs and not to be influenced by instrumentalization and politicization. Political contestation around rights to reproductive and sexual health remains a global challenge, resulting in women paying a high price in terms of their health and lives. In adopting the 2030 Agenda for Sustainable Development, States committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. A strong commitment to women's sexual and reproductive rights in international and national law,

policies and programmes is crucial for achieving gender equality and ensuring women's and girl's right to health and well-being.

25. Many drug therapy protocols and other medical treatments and interventions administered to women are based on research conducted on the male of the species without any investigation and adjustment for biological and gender differences. Equality requires the conduct of medical research on the basis of women's experience and biological differences. It also requires adequate attention to be paid to the particular health risks to which women are disproportionately exposed, such as depression and suicide, and proper gender-sensitive treatment of diseases which tend to be considered, inaccurately, as typically masculine, such as cardiovascular diseases.

26. Women's specific health and safety needs require protection against gender-based violence that affects their physical integrity and mental health, including in health-care settings.

27. The social, religious and cultural factors that disregard the dignity of girls and women must be tackled to achieve women's right to equality in health and safety.

C. Discriminatory practices

28. Discriminatory practices in the area of health and safety occur at all stages of women's life cycle. Multiple discrimination merits particular consideration and remedies. Denying women access to services which only they require and failing to address their specific health and safety, including their reproductive and sexual health needs, are inherently discriminatory and prevent women from exercising control over their own bodies and lives. Gender-based discrimination in the administration of medical services also violates women's human rights and dignity.

29. Denial of access to essential health services with respect to termination of pregnancy, contraception, treatment for sexually transmitted diseases and infertility treatment has particularly serious consequences for women's health and lives. Women may be denied such services through criminalization, reduction of availability, stigmatization, deterrence or derogatory attitudes of health-care professionals. In reality, denial of access drives service provision underground into the hands of unqualified practitioners. This exacerbates the risks to the health and safety of the affected women. Persistently high maternal mortality rates often reflect a lack of investment in and underprioritization of services required only by women

30. Discrimination is sometimes manifested in humiliating treatment women that may face in facilities that are dedicated exclusively to them, such as birthing facilities where, as repeatedly stressed by United Nations human rights mechanisms and WHO, they are too often subjected to degrading and sometimes violent treatment.

31. Discrimination against women is also manifest in the unequal provision of health services required by both women and men. This has been especially severe in countries where women have been excluded from receiving medical treatment by male doctors on the grounds of "modesty".

32. Discriminatory laws and practices have contributed to a deplorable global situation with respect to women's health and safety which calls for urgent, immediate and effective actions. According to WHO, an estimated 225 million women are deprived of access to essential modern contraception. Pregnancy and childbirth-related complications resulted in the deaths of almost 300,000 women worldwide in 2013. About 22 million unsafe abortions take place annually and an estimated 47,000 women die from complications resulting from unsafe abortion each year. Breast and cervical cancer remain the leading cancers among

women aged 20-59 years, resulting in 1 million deaths, the majority in low- and middle-income countries where screening, prevention and treatment are almost non-existent. Young women bear the brunt of new HIV infections. One in three women under 50 has experienced physical and/or sexual violence by an intimate partner or family member. At least 200 million women and girls have been subjected to female genital mutilation.

1. Discrimination throughout a woman's life cycle

33. The Working Group notes with concern that issues relating to women's health are not addressed in a holistic manner on political and health agendas at the national and international levels. Policies regarding women's health services are often limited to questions of "maternal health". Despite the importance of prioritizing this issue, such a restrictive focus fails to recognize the full spectrum of women's rights to sexual and reproductive health at all stages of their life cycle and contributes to the instrumentalization of women's bodies, viewing them mainly as a means of reproduction.

34. Many girls are exposed to a wide variety of practices which are harmful to their health and well-being, such as female genital mutilation, discrimination in food allocation resulting in malnutrition and discrimination in access to professional health care. Furthermore, early marriage and adolescent pregnancy have a long-lasting impact on girls' physical integrity and mental health. Pregnancy and childbirth are together the second leading cause of death among 15- to 19-year-old girls globally, putting them at the highest risk of dying or suffering serious lifelong injuries as a result of pregnancy. For example, up to 65 per cent of women with obstetric fistula, which is a severely disabling condition and often results in social exclusion, develop this condition as adolescents.

35. Adolescent girls are particularly exposed to gender-based violence in the family and on their way to or at school, with extremely harmful impacts on their physical and mental health. In its resolution 70/137 the General Assembly called upon all States to improve the safety of girls on the way to and from school, taking steps to ensure that all schools are accessible, safe, secure and free from violence and providing separate and adequate sanitation facilities that provide privacy and dignity.

36. In some countries, adolescent girls are deterred from accessing information and services for family planning and termination of pregnancy that are needed to protect their health and safety and prevent unwanted high-risk pregnancies, including the requirement of third party authorization.

37. During pregnancy, many women are vulnerable to malnutrition owing to discrimination in the allocation of food. This can result in a serious and irreversible deterioration of women's general health and increase the risk of premature delivery, low birth weight and birth defects. After childbirth, such discrimination can continue to affect women's health, including in connection with breastfeeding. Furthermore, as stated by the Special Rapporteur on the right to food, structural violence is an underexamined barrier to women's right to adequate food and nutrition. Gender-based violence, which is a primary form of discrimination, can impede women from accessing adequate food and nutrition.

38. Delays in seeking appropriate medical care, in reaching an appropriate health facility and in receiving appropriate care once at a facility, along with the lack of accessible maternal health care, are the main reasons behind high rates of maternal mortality and morbidity. A human rights-based approach that provides a functioning health system with adequate supplies, equipment and infrastructure as well as an efficient system of communication, referral and transport are therefore essential to eliminate these preventable deaths and to ensure women's rights to health and life.

39. Women's mental health during pregnancy, childbirth and the post-partum period requires both stability in their environment and emotional support. Reports of disrespect

and ill treatment during childbirth in health facilities in many countries provide a deeply distressing picture of the extent of women's exposure to degrading treatment, lack of privacy, and even verbal and physical violence. Pregnant women are sometimes refused pain relief during labour or anaesthesia during a termination of pregnancy by curettage. The use in some countries of custodial or punitive rather than educative measures to prevent injury to the fetus as result of drug or alcohol consumption by addicted pregnant women is another manifestation of gender discrimination.

40. Women have a longer life expectancy and are particularly exposed to neglect and abuse in older age, including in health-care settings, and higher risks of diseases such as Alzheimer's disease and other forms of dementia. A gender- and age-sensitive approach needs to take into account the specific needs for care and protection of older women, including those widowed, living alone or displaced, those with dementia or other disability, those in need of palliative and geriatric care and those in emergency situations; these women are most at risk of multiple forms of discrimination, violence and poverty.

41. In addition, problems associated with ageing affect women disproportionally as a result of the cumulative effect of discriminatory practices women face over the course of their lives, as the Working Group described in its report on discrimination against women in economic and social life (A/HRC/26/39). Women are more likely to take care of men and to be left without spousal support. At the same time, they are more likely to suffer economic disadvantages, exacerbated by discriminatory pension systems that fail to produce equal outcomes for women, and to be excluded from social security and health insurance schemes. They are thus at greater risk of living in poverty. The mere recognition of equal rights for all, without distinction, is thus insufficient to ensure in practice the enjoyment by older women of all human rights, including the right to health.

2. Women facing multiple and intersecting forms of discrimination

42. Recognizing and addressing the nature and consequences of multiple and intersectional discrimination against women in national laws and practices is essential for protecting women's health and safety. Factors such as socioeconomic, minority and ethnic status, religion, race, sexual orientation, gender identity and expression, disability and bodily diversity exacerbate the discrimination that women face and infringe upon their ability to protect their health and safety.

Women and poverty

43. The Working Group is particularly concerned about the discrimination experienced by women because of their economic status. It has witnessed first-hand during its country visits that women living in poverty are disparately affected in their access to health services, particularly reproductive and sexual health and preventive health care.

44. There is growing concern about the feminization of poverty and the disparate impact of global economic crises, austerity measures and climate change on women's health and safety. Gender inequality persists in all regions, and women and girls continue to be overrepresented among the world's population living in poverty. Women and girls, particularly those living in the global South, are disproportionately burdened by the costs of these rapid changes, to the detriment of their personal health and well-being.

Women with disabilities

45. Women with disabilities face particular barriers in accessing health care for reasons of cost, distance, discriminatory attitudes, and lack of physical access or information. This seriously limits their access to immunization, reproductive health care and cancer screening. In some settings women with disabilities, particularly intellectual disabilities, are

subjected to forced sterilization or termination of pregnancy or to long-term contraception, with relatives or doctors taking decisions on their behalf without their informed consent, in violation of their right to exercise legal capacity guaranteed under the Convention on the Rights of Persons with Disabilities.

46. Women with disabilities are disproportionately subject to intimate-partner violence, owing to the mutually reinforcing dynamics of gender and disability.

47. The Special Rapporteur on the rights of persons with disabilities has called on States to guarantee women with disabilities safe participation in matters affecting their lives, especially in relation to sexual and reproductive rights and gender-based violence, including sexual violence, matters which are cited in a recent study as high-priority concerns for women and girls with disabilities.

Women and HIV/AIDS

48. Women are disproportionately vulnerable to HIV/AIDS owing to various factors, including gender-based violence and lack of autonomy to negotiate safe and responsible sexual practices and make informed health-related decisions. Even when women living with HIV/AIDS are able to access health services, they often face stigma and discrimination on the part of health-care professionals, ranging from abuse to denial of services. Laws, policies and practices that prevent women living with HIV from bearing children through, for example, forced termination of pregnancy and forced sterilization constitute an extreme form of discrimination.

Women migrants

49. Women migrants are often at great risk of being subjected by public authorities or private individuals to all manner of violence, exploitation, trafficking and slavery while in transit or in detention. These practices can amount to cruel, inhuman or degrading treatment or torture.

50. Women migrant workers, especially those in irregular situations, have greater difficulty in accessing almost all forms of health care, including maternal care, emergency care and treatment for chronic diseases and mental health problems, because they are often denied these rights legally and/or they fear arrest and deportation. In some countries, while legal access to health care for migrant women has been expanded, they still do not receive needed medical services because health-care providers often refuse treat them.

51. Even where they are entitled to emergency health care, women migrant domestic workers are often excluded from preventive reproductive and sexual health services, as well as gynaecological and obstetric care, because of their status and lack of access to insurance or national health schemes.

52. The pattern of physical, sexual and psychological abuse of migrant domestic workers is widespread. These women are often exposed to health and safety risks without being provided with proper information or adequate protection. Furthermore, the working and living conditions of many undocumented domestic workers, which are tantamount to slavery, and the separation from family members cause serious health, particularly mental health, problems.

53. Migrant women may be subject to mandatory pregnancy tests upon arrival in some countries; if the test is positive, they are dismissed and/or deported. Furthermore, pregnancy tests can be imposed on migrant domestic workers during the course of their employment, leading to pregnant women losing their jobs and/or seeking termination of the pregnancy, sometimes by means of unsafe practices, especially in countries that criminalize induced termination. Migrant women have been charged with "illegal sexual relationships" when

they become pregnant, including following rape. They are held in detention centres in deplorable conditions pending their deportation, or face severe punishment, including the death penalty in countries where sexual relationships outside marriage are criminalized.

Indigenous women

54. Indigenous women experience a complex spectrum of mutually reinforcing human rights abuses which is influenced by intersecting forms of discrimination and marginalization, reinforced by patriarchal power structures and past and present forms of violations of the right to self-determination and control of resources. These intersecting forms of discrimination have profound health consequences for indigenous women, especially for their reproductive and sexual health. The Special Rapporteur on the rights of indigenous peoples has reported (see A/HRC/30/41) about the barriers to reproductive and sexual health services encountered by indigenous women as well as past and recurrent human rights violations in relation to their sexual and reproductive rights. For example, indigenous women experience disproportionately higher levels of maternal mortality, indigenous girls are overrepresented among pregnant teenagers and indigenous women have lower rates of contraceptive use and higher rates of sexually transmitted diseases, including HIV/AIDS. Historically, there have also been instances of serious violations of indigenous women's rights to reproductive health in the context of the denial of the rights of indigenous peoples to self-determination and cultural autonomy. Those violations include forced sterilization of indigenous women and attempts to force them to have children with non-indigenous men as part of policies of cultural assimilation. Indigenous women may also face barriers to preventive care services that support their right to health, such as screening for ovarian and breast cancer.

55. The deplorable health outcomes for indigenous women are linked to decades of oppression and human rights violations against indigenous peoples, and against indigenous women in particular. Furthermore, non-indigenous health systems generally do not take into account the indigenous concept of health and health care, thereby creating barriers to access by indigenous women. Data usually fail to capture information on indigenous communities, rendering them "invisible". Even when such information exists, it is generally not disaggregated by sex. Additionally, indigenous women are disproportionately affected by illness owing to reduced coping capacity caused by the denial of other human rights and by extreme poverty.

Rural women

56. Rural women are particularly affected by patriarchal gender stereotypes and roles and are extremely vulnerable to harmful practices such as early or forced marriage and female genital mutilation, as well as to violence and poverty. These practices have a negative impact on their right to health. Rural women are usually particularly disadvantaged in accessing health-care services, including reproductive and sexual health services.

Minority women

57. As highlighted by the Special Rapporteur on minority issues (A/HRC/31/56), minority women, including women affected by discrimination based on caste, are particularly vulnerable to violations of their right to health, including reproductive and sexual health. Women members of "lower caste" groups present the worst health outcomes, especially in terms of life expectancy, access to maternal care, nutrition and incidence of infections. Roma women are the subjects of degrading stereotypes, depicted as "fertile" and "promiscuous"; this increases their vulnerability to gender-based violence and forced sterilization.

Women's sexual orientation and gender identity

58. In many settings, especially where same-sex consensual sexual behaviour is prohibited, lesbian, bisexual and transgender persons are deterred from seeking health services out of fear of being arrested and prosecuted. Even in countries where same-sex sexual orientation is not criminalized, lesbians are often discriminated against and mistreated by medical providers, which deters them from seeking health services. In some settings, they are subjected to coercive, inhumane and degrading practices such as "corrective" or punitive rape. Transgender persons are often subjected in law and practice to compulsory medical interventions without being given an opportunity for informed decision-making and choice. Their gender identity is pathologized in many countries and they are often subjected to mental and physical examinations and treatments and forced to undergo "conversion therapies". Transgender persons' biological needs, such as transition-related medical services, screening for cervical cancer, termination of pregnancy and contraception, are often refused by service providers.

Women deprived of liberty

59. Women in detention have specific health needs, particularly in terms of mental and reproductive health care, that are often neglected. Preventive services related to cervical and breast cancer are often unavailable and antiretroviral therapy, even for pregnant women living with HIV/AIDS, is completely absent in some facilities. The lack of adequate access to hygiene facilities and products for women prisoners is a typical and crucial concern in all regions of the world, jeopardizing the dignity and health of women prisoners. Practices such as shackling pregnant inmates during labour still occur in some countries. Detained women also face violence, including sexual violence from other prisoners or by staff.

60. Women prisoners show high rates of mental health problems owing to violence and trauma to which they had been exposed and which are exacerbated by imprisonment. Concerns about their children also have a significant impact on the mental health of women prisoners, especially when they are breastfeeding; separation from their children creates anxiety and guilt, resulting in great suffering. Women are more likely to harm themselves or attempt suicide while in detention than men. Extensive reliance on preventive use of psychotropic medication for "safety" reasons in such situations is an example of overmedicalization.

D. Instrumentalization of women's bodies

61. Throughout their life cycle, women's bodies are instrumentalized and their biological functions and needs are stigmatized and subjected to a politicized patriarchal agenda. States have also often treated women instrumentally as tools with which to implement population programmes and policies. This is sometimes carried out through the use of criminal sanctions and often under the guise of protecting women's health and safety and with cultural or religious justifications.

62. Much of the discrimination in access to health services and the resulting preventable ill health of women, including maternal mortality and morbidity and infertility, can be attributed to the instrumentalization of women's bodies for political, cultural, religious and economic purposes.

1. Negation of autonomy

63. The instrumentalization of women's bodies may result in conditioning women's access to medical assistance on the consent of a spouse or male guardian, causing withholding or delay of treatment, curtailment of women's autonomy and denial of respect

for privacy and obstructing their access to health care, particularly reproductive and sexual health care. Patriarchal negation of women's autonomy in decision-making leads to violation of women's rights to health, privacy, reproductive and sexual self-determination, physical integrity and even to life.

2. Effects of son preference

64. In patriarchal cultures, the preference for sons leads to the prioritization of boys' and men's health before that of women and girls, resulting in discriminatory practices such as female infanticide. This is evident in cultural customs relating to food which cause girls and women, including pregnant and nursing women, to suffer disproportionately from malnutrition.

3. Harmful gender stereotypes

Objectification of women

65. The instrumentalization of women's bodies as objects to serve sexual and other purposes leads to practices such as invasive cosmetic procedures. Unhealthy dieting, particularly among adolescent girls, can have disastrous health consequences, including eating disorders such as anorexia and bulimia.

66. According to WHO, a body mass index under 16 represents severe thinness. Setting minimum standards of weight for fashion models in line with health guidance via national legislation and policies and/or regulations by modelling agencies as well as advertising campaigns embracing the diversity of female forms are good practices. The development of new models of dolls with body proportions corresponding to those of healthy women is another.

Stigmatization of women's health

67. Stigma is a deeply entrenched social and cultural phenomenon which lies at the root of many human rights violations and results in entire population groups being disadvantaged and excluded, as the Special Rapporteur on the right to water and sanitation has noted (A/HRC/30/39). Women are exposed to harmful gender stereotypes or taboos regarding natural and biological functions such as menstruation, breastfeeding and menopause. Diagnosis of mental illnesses in women is biased so as to stigmatize them and has been used as a justification for institutionalizing women unnecessarily against their will.

68. Menstruation is surrounded by stigma, resulting in the ostracism of and discrimination against women and girls. In some cultures menstruating women and girls are considered to be contaminated and impure and restrictions and interdictions during menstruation are imposed on them. Women and girls may continue to harbour internalized stigma and are embarrassed to discuss menstruation even where there are no restrictions. They live with a lack of privacy for cleaning and washing, a fear of staining and smelling and a lack of hygiene in school toilets or separate sanitation facilities.

69. Furthermore, many girls do not receive sexuality education, including knowledge about the functioning of their bodies, and hygienic materials for menstruation are either unavailable or too costly. They are forced to use improvised, unhygienic materials that may lead to leaking and infections.

70. The stigma and shame generated by stereotypes around menstruation have severe impacts on all aspects of women's and girls' lives, on their dignity and well-being as well as on their right to education and to employment, as they may feel obliged to stay home from school or work every month because of appropriate facilities and hygienic items are

not available. Characterizing women's menstrual pain as "neurotic" tends to make women reluctant to seek help, which can delay diagnosis of, for example, the severely disabling disease of endometriosis, in which tissue that normally grows inside the uterus grows in an abnormal anatomical location.

71. Prejudices surrounding menopause may affect women's confidence in professional and public life, owing to age-based discrimination in the workplace. In some societies, this question is poorly addressed and understood, if at all. Medicalization through hormone replacement therapy, and pressure on active women to use it, even where there are health contraindications, can have a detrimental effect on women's mental health.

72. Similarly, instrumentalization and stigmatization are at work regarding breastfeeding in public spaces and at workplaces. Aside from the fact that breastfeeding is often promoted or discouraged for economic reasons, it may be viewed as inappropriate even in countries where the practice is legally protected, exposing women to unnecessary stress and pressure from intimidation and harassment. According to the United Nations Children's Fund (UNICEF), the majority of the approximately 830 million women workers worldwide do not enjoy workplace policies that support nursing mothers.

4. Pathologization and overmedicalization of women

73. Viewing women's behaviour and biological physiology, in particular their reproductive functions and sexuality, as symptomatic of medical problems reflects a history of gendered pathologization. Historically, pathologization, unnecessary medicalization and institutionalization in mental care facilities have functioned as forms of social control exercised by patriarchal establishments to preserve the gender roles of women. Pathologization of women's behaviour has been evidenced in psychiatric diagnoses, which often directly target perceived immoral activity such as unconventional sexual activity or intellectual independence as a source of mental illness or disorder.

74. The Working Group is concerned that many national laws and policies provide for overmedicalization of certain services that women need to preserve their health without a justified medical reason. These include requirements that only doctors can perform certain services, such as pharmaceutical termination of pregnancy or obstetric care. In many countries, women are not given a free choice between different ways of giving birth. Caesarian sections, when medically justified, can be crucial in preventing maternal and perinatal mortality and morbidity. However, studies conducted by WHO demonstrated that performing caesarian sections on more than 10 per cent of women does not lead to improvement in mortality rates. Caesarean section rates of 30 per cent in some countries demonstrate overmedicalization of childbirth, with the risks of obstetrical complications and health problems.

75. Overmedicalization may result in reduced access to or affordability of services needed by women and a barrier to developing adequate alternative services which can be competently provided by nurses, midwives or auxiliary nurses, either at clinics or at home. Such "task shifting", particularly in places where there are few qualified doctors, would make services more accessible. Similarly, restricting authorization for the use of contraceptives to a medical practitioner is a barrier to access. Allowing pharmacists to provide contraceptives, including emergency contraceptives, over the counter is essential for effective availability, especially for economically disadvantaged women or adolescent girls.

5. Discriminatory use of the criminal law

76. The discriminatory use of criminal law, punitive sanctions and legal restrictions to regulate women's control over their own bodies is a severe and unjustified form of State

control. This can include punitive provisions in criminal, civil and administrative laws and regulations governing extramarital consensual sex, same-sex consensual adult relations, gender non-conforming expressions, provision of reproductive and sexual education and information, termination of pregnancy and prostitution/sex work. The enforcement of such provisions generates stigma and discrimination and violates women's human rights. It infringes women's dignity and bodily integrity by restricting their autonomy to make decisions about their own lives and health.

77. States also violate women's right to health and safety where women are penalized for sexual or reproductive conduct that should not be criminally prohibited, such as adultery, prostitution or termination of pregnancy; States also violate the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment where they impose penalties such as stoning and lashing.

78. Criminalization of behaviour that is attributed only to women is discriminatory per se and generates and perpetuates stigma. The threat of criminal punishment restricts women's access to sexual and reproductive health-care services and information and acts as a deterrent to health-care professionals, thus barring women's and girls' access to health-care services.

Criminalizing and restricting the provision of and access to safe, legal services for termination of pregnancy

79. Criminalization of termination of pregnancy is one of the most damaging ways of instrumentalizing and politicizing women's bodies and lives, subjecting them to risks to their lives or health in order to preserve their function as reproductive agents and depriving them of autonomy in decision-making about their own bodies. Restrictive laws apply to 40 per cent of women worldwide. In some countries, as a result of retrogressive anti-abortion laws, women are imprisoned for having had a miscarriage, imposing an intolerable cost on the women, their families and their societies.

80. As demonstrated by WHO data, criminalizing termination of pregnancy does not reduce the need for it. Rather, it is likely to increase the number of women seeking clandestine and unsafe solutions. Countries in Northern Europe, where women gained the right to termination of pregnancy in the 1970s or 1980s and are provided with access to information and to all methods of contraception, have the lowest rates of termination of pregnancy. Ultimately, criminalization does grave harm to women's health and human rights by stigmatizing a safe and needed medical procedure. In countries where induced termination of pregnancy is restricted by law and/or otherwise unavailable, safe termination of pregnancy is a privilege of the rich, while women with limited resources have little choice but to resort to unsafe providers and practices. This results in severe discrimination against economically disadvantaged women, which the Working Group has highlighted during its country visits.

81. It is important to recall that the use of effective contraception can result in lowering the incidence of unintended pregnancy. However, contraception cannot eliminate women's need for access to termination of pregnancy, for example in the case of rape. In addition, no method of contraception is 100 per cent effective in preventing pregnancy.

82. In addition, restrictions on access to information on termination of pregnancy and services can deter women from seeking professional medical attention, with detrimental consequences for their health and safety. Examples of restrictions include criminalization of medical practitioners who provide these services; prohibiting access to information on legal termination of pregnancy; requiring third-party authorization from one or more medical professionals, a hospital committee, a parent, guardian or spouse; conscientious objection by health practitioners without provision of an alternative; requiring compulsory waiting

periods; and excluding coverage for termination of pregnancy services under health insurance. None of these requirements is justified on health grounds.

83. International and regional human rights bodies have called on States to decriminalize access to termination of pregnancy and to liberalize laws and policies in order to guarantee women's access to safe services. Treaty bodies, including the Committee on the Elimination of Discrimination against Women and the Committee on Economic, Social and Cultural Rights, have requested States, through their jurisprudence, their general comments/recommendations and their concluding observations, to review national legislation with a view to decriminalizing termination of pregnancy and to ensure a woman's right to termination of pregnancy where there is a threat to her life or health, or where the pregnancy is the result of rape or incest. The Committee against Torture and the Human Rights Committee have determined that, in some cases, being forced to carry an unwanted pregnancy to term amounts to cruel and inhuman treatment.

Criminalization of women who engage in prostitution/sex work

84. Criminal laws and other punitive regulations have imposed custodial sentences on women involved in prostitution/sex work in a manner that has been shown to harm rather than protect them. The Working Group considers that the criminalization of women in prostitution/sex work places them in a situation of injustice, vulnerability and stigma and is contrary to international human rights law. It notes that the Convention on the Elimination of All Forms of Discrimination against Women calls for prohibition of the exploitation of prostitution and not for punishment of the women in prostitution/sex work themselves; the well-established position of the Committee on the Elimination of Discrimination against Women that women should not be criminalized for prostitution; and the stipulation in the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (Palermo Protocol) that efforts should be made to discourage the demand that fosters all forms of exploitation of women, including trafficking for sexual exploitation.

85. International organizations and human rights bodies have called on States to ensure, at a minimum, that women in prostitution/sex workers have the right to access sexual health services; are free from violence or discrimination, whether committed by State agents or private persons; and have access to equal protection of the law. In particular, States should also ensure that law enforcement officials serve a protective function, as opposed to engaging in or perpetuating violence against women in prostitution/sex workers. A number of States have introduced regulations that cover health and safety issues, including access to health services, medical insurance and social security benefits that have had a positive impact on women engaged in prostitution/sex work.

E. Autonomous, affordable and effective access to health care

1. Autonomous access

86. Autonomous access to health care means ensuring a woman's right to make decisions concerning her health, fertility and sexuality free of coercion and violence. Key to this is the notion of choice. The rights to informed consent and confidentiality are crucial to ensuring that women can make decisions freely. These rights impose corresponding duties upon health-care providers, who are bound to disclose information about proposed treatments and alternatives in order to aid informed consent and to respect the right to refuse treatment; likewise, they are bound to maintain confidentiality to allow women to make private decisions without the interference of others whom they have not chosen to consult and who might not have their best interests at heart. Autonomy means that a woman seeking services in relation to her health, fertility or sexuality is entitled to be treated as an

individual in her own right, the sole beneficiary of the service provided by the health-care practitioner and fully competent to make decisions concerning her own health. This is a matter of, among other things, a woman's right to equality before the law.

2. Affordable health care

87. Even where significant resources are being put in place to provide universal health care, women continue to have unequal access to good-quality health-care services in many countries. This is often because the health services that only women need are excluded from insurance coverage and are not affordable.

88. Economically disadvantaged women who do not have the means to access private health care and services are disparately affected by barriers created by unaffordability. It is therefore important for States to ensure that all health care is affordable and to remove legal restrictions that in effect discriminate against women who are economically disadvantaged.

89. Health care is often unaffordable owing to discriminatory health insurance coverage. Some health insurance policies and programmes exclude various aspects of reproductive health care, including modern forms of contraception, termination of pregnancy and maternal care. Alternatively, some private health insurance schemes insure women's reproductive health needs but add a surcharge to the premiums paid by women. Good practice includes measures that discourage insurance companies from charging women more for health insurance than men because of perceived higher costs associated with women's reproductive health needs.

90. Public funding is necessary to subsidize primary health-care services, including medications, contraceptives, legal termination of pregnancy and treatment of sexually transmitted infections. Such services should be affordable and, in the case of economically disadvantaged women, provided free of charge. User or "informal" fees for health-care services increase the risk that these women will either forgo services or resort to substandard services, perhaps from unqualified providers.

91. Good practices include listing as essential medicines all those recommended as necessary for women's health in the WHO Model List of Essential Medicines, public subsidization of the cost of women's health-related services for everyone and subsidies to women of a given age or income.

92. Unaffordability of medicines is also closely linked to intellectual property laws, many of which provide exclusive patents for new medicines for long periods. However, intellectual property laws that fail to address the medical needs of women obstruct access to medicines by pushing up the price and by impeding the production and distribution of low-cost generic drugs. The right to health requires States to ensure that the pharmaceutical companies that hold a patent on essential medicines and medical devices make use of all the arrangements at their disposal to render the medicines accessible to all.

3. Effective access

Conscientious objection to providing health services

93. Inadequately regulated conscientious objection may constitute a barrier for women when exercising their right to have access to reproductive and sexual health services. The jurisprudence of human rights treaty bodies states that where conscientious objection is permitted, States still have an obligation to ensure that women's access to reproductive health services is not limited and that conscientious objection is a personal, not an institutional, practice.

94. A number of countries have legal guarantees that protect women in the case of conscience-based refusal of care. They include the requirement of referral to non-objecting providers, registration/written notice to the employer and/or a government body, disclosure of information to patients about the provider's status as a conscientious objector, provision of services in cases of emergency, and restriction of the right to conscientious objection to the individuals directly involved in the medical intervention and not institutions or those indirectly involved, such as pharmacists. The Working Group reiterates that the enjoyment of the right to freedom of religion or belief cannot be used to justify gender discrimination and therefore should not be regarded as a justification for hindering the realization of women's right to the highest attainable standard of health.

Education and information

95. Restrictions in many countries on girls' and women's access to unbiased, quality education, including evidence-based comprehensive sexuality education, and information about where and how to obtain essential health services prevent women from making free and informed decisions about their health and safety and hence obstruct proper, informed access to health care. This is particularly true for adolescents and marginalized women facing multiple and intersectional forms of discrimination. Such restrictions are manifestations of censorship that limit women's and girls' choices.

96. States have an obligation to provide education, one of whose aims is to facilitate access to scientific and technical knowledge. This is of crucial importance with respect to questions of sexuality, reproduction and health education. States have an obligation to allow information about health matters to flow freely, without State interference on moral or other grounds. It also encompasses the possibility for non-State actors to disseminate information, including in relation to sexuality and sexual and reproductive health services. However, States also have an obligation to address and eliminate harmful and wrongful gender stereotypes that contribute to the violation of women's right to health and safety.

97. A growing number of States worldwide have confirmed their commitment to comprehensive sexuality education as an essential priority for achieving national development, health and education goals. In its resolution 70/137, the General Assembly called upon all States to develop and implement educational programmes and teaching materials, as well as teacher education and training programmes for both formal and non-formal education, including comprehensive evidence-based education on human sexuality, based on full and accurate information, for all adolescents and youth; to modify the social and cultural patterns of conduct of men and women of all ages; to eliminate prejudices; and to promote and build decision-making, communication and risk reduction skills for the development of respectful relationships based on gender equality and human rights.

IV. Conclusions and recommendations

98. In the context of women's and girls' health and safety, equality means the provision of differential services, treatment and medicines in accordance with their specific biological needs, throughout their life cycle. In many countries there is discriminatory exclusion and neglect of women in providing the highest attainable standard of health for women. Discrimination is particularly evident regarding women's right to reproductive and sexual health. It is exacerbated in the case of women members of marginalized groups. Discrimination against women and girls leading to the violation of their right to health and safety denies their right to human dignity.

99. The Working Group found that instrumentalization and politicization of women's biological functions in many countries subjects legislation and policies regarding women's and girls' health and safety to patriarchal agendas, especially regarding reproductive and sexual health and mental health. The Working Group found manifestations in all regions of instrumentalization, taboos regarding menstruation and breastfeeding and stereotypes which result in harmful practices such as female genital mutilation or which have a negative impact on women's body image, leading to their seeking invasive cosmetic procedures.

100. Women's access to health services in many countries is not autonomous, affordable and effective, elements which are essential for States to respect, protect and fulfil women's and girls' rights to life, health, privacy, equality and human dignity. A major barrier is lack of affordability as a result of exclusion from insurance for treatments specifically needed by women and girls or exclusion of groups of women such as migrants. Non-affordability severely discriminates against women living in poverty. Barriers also include restrictive legislative requirements, biased and stigmatized provision of services and conscientious objection to providing services.

101. Health services are provided by various actors, State and non-State. All actors have some form of responsibility for providing equal access for women to the highest attainable standard of health, including with regard to their reproductive and sexual health. The State has a due diligence obligation to ensure that private actors do not discriminate against women.

102. The result of the various forms of discrimination against women in the provision of health services is the costly and tragic phenomenon of women's preventable ill health.

A. General recommendations

103. The Working Group calls upon the Human Rights Council to urge States to take all necessary measures to respect, protect and fulfil women's right to the enjoyment of the highest attainable standards of health worldwide, including regarding their reproductive and sexual health, and to dedicate priority attention to a thorough stocktaking, including by convening an appropriate forum to tackle this crucial issue.

104. The Working Group calls upon all Member States to reaffirm and respect the commitments they made in Beijing and in Cairo and in the Sustainable Development Goals to implement the comprehensive provisions concerning women's health in the agreements they adopted and to develop national laws, policies and programmes within the framework of international human rights standards.

B. Equality and non-discrimination

105. The Working Group recommends that States:

(a) Apply human rights standards and principles of equality, non-discrimination and empowerment of women as the framework for all interventions regarding women's health and safety;

(b) Be guided by an understanding of women's right to equality, which requires differential treatment in health, including and beyond their sexual and reproductive health, in designing policy measures and resource allocations;

(c) Take into account the impact of women's safety on their physical and mental health and protect women and girls from violence at home, on their way to or at school and in other public spaces and in health facilities;

(d) Adopt a holistic approach towards women's health and safety by looking at their full life cycle from childhood to old age as interconnected phases with distinct considerations and needs, and in this regard:

(i) Take effective measures to prevent child marriage and adolescent pregnancies and provide girls with comprehensive education based on scientific evidence on matters of health, including sexuality;

(ii) Address the gender discrimination that exists in some cultures in the provision of food to the girl child, including through the empowerment of women and girls;

(iii) Allow pregnant girls and adolescents to terminate unwanted pregnancies, as a measure of equality and health, so that they can complete their school education and protect them from the high risk to life and health, including from obstetric fistula, in continuing to bring a pregnancy to term;

(iv) Reduce maternal mortality and morbidity by ensuring proper prenatal, birthing and post-natal care, including, where necessary, safe termination of pregnancy.

(v) Reduce the high incidence of maternal mortality among women with HIV/AIDS, both by preventing infection, particularly of women in prostitution/sex workers, and by free and secure provision of condoms and of antiretroviral treatment for pregnant women;

(vi) Provide adequate nutrition and free services for pregnant and lactating women, as required by the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women;

(vii) Ensure that laws, policies and practices mandate respect for women's autonomy in their decision-making, especially regarding pregnancy, birthing and postnatal care;

(viii) Provide gender- and age-sensitive health-care services for older women, taking cognizance of their heightened health and safety vulnerability;

(e) Provide special protection and support services to women facing multiple forms of discrimination, and in this regard:

(i) Ensure that health services, including reproductive and sexual health, for women with disabilities are available and accessible on an equal basis with others and that their autonomy and decision-making, including in relation to their sexuality and reproduction, are guaranteed in accordance with the principles of the Convention on the Rights of Persons with Disabilities;

(ii) Provide health-care coverage for migrant women and domestic workers, whose sexual and reproductive health, preventive health care and protection against gender-based violence are otherwise prejudiced;

(iii) Ensure social and health-care benefits, entitlements and protection to lesbians and bisexual and transgender persons without discrimination;

(iv) Provide access to preventive and remedial health services for women in prison, including in relation to cervical and breast cancer, contraception,

antiretroviral therapy and gender transition, and take all necessary measures to protect them from violence;

(v) Allow non-custodial sentences for pregnant women and women with dependent children in accordance with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules).

C. Instrumentalization of women's bodies

106. The Working Group recommends that States:

(a) Take measures to combat and eliminate, in legislation and policies, cultural practices and social stereotypes, all forms of instrumentalization of women's bodies and biological functions;

(b) Eliminate harmful gender stereotypes, which could lead to anorexia and bulimia and invasive cosmetic procedures;

(c) Prevent exclusion from the public space during menstruation or breastfeeding and prevent discrimination in relation to menopause in the workplace;

(d) Take and implement strong and efficient measures to prevent female genital mutilation and other harmful practices;

(e) Decriminalize sexual and reproductive behaviours that are attributed exclusively or mainly to women, including adultery and prostitution, and termination of pregnancy;

(f) Combat stereotyping and empower girls to take care of their own health and safety from a young age, both at school and at home, and inform and empower women regarding their own bodies at all stages of their lives;

(g) Regulate birthing facilities to ensure respect for women's autonomy and privacy and human dignity, including respect for women's choice regarding home deliveries provided there are no specific medical contraindications;

(h) Prevent instrumentalization of women in the birthing process and ensure that penalties are incurred for gynaecological or obstetrical violence, including performing abusive caesarean sections, refusing to give women pain relief during birth or surgical termination of pregnancy and performing unnecessary episiotomies;

(i) Use educational and social work alternatives instead of custodial or punitive measures to prevent injury to the fetus as a result of drug or alcohol consumption by addicted pregnant women;

(j) Monitor and prevent the use of mental health to institutionalize women unnecessarily as a social control mechanism.

107. In relation to reproductive and sexual health care, the Working Group recommends that States:

(a) Abolish bans on contraception, including emergency contraceptives, and provide access to affordable modern contraceptives;

(b) Repeal restrictive laws and policies in relation to termination of pregnancy, especially in cases of risk to the life or health, including the mental health, of the pregnant woman, rape, incest and fatal impairment of the fetus, recognizing that such laws and policies in any case primarily affect women living in poverty in a highly discriminatory way;

(c) **Recognize women's right to be free from unwanted pregnancies and ensure access to affordable and effective family planning measures. Noting that many countries where women have the right to abortion on request supported by affordable and effective family planning measures have the lowest abortion rates in the world, States should allow women to terminate a pregnancy on request during the first trimester or later in the specific cases listed above;**

(d) **Discontinue the use of criminal law to punish woman for ending a pregnancy and provide women and girls with medical treatment for miscarriage and complications of unsafe termination of pregnancy;**

(e) **Eliminate discriminatory barriers to access to legal termination of pregnancy that not based on medical needs, such as waiting periods for implementation of the decision to terminate a pregnancy, authorization requirements for reproductive health clinics and staff, and unduly restrictive interpretations of legal grounds for termination of pregnancy.**

D. Autonomous, affordable and effective access to health care

108. **The Working Group recommends that States:**

(a) **Ensure that access to health care is autonomous, affordable and effective;**

(b) **Address underlying factors which negate women's autonomy in decision-making regarding their own lives, health or bodies, through education, provision of information and monitoring mechanisms to ensure that their autonomy is respected at all levels of the health-care system;**

(c) **Invalidate conditioning of women's and girls' access to health care on third-party authorization;**

(d) **Provide training to health providers, including on gender equality and non-discrimination, respect for women's rights and dignity and recognition of alternative medicine;**

(e) **Provide non-discriminatory health insurance coverage for women, without surcharges for coverage of their reproductive and sexual health;**

(f) **Include contraception of choice, preventive care and treatment for cervical and breast cancer, termination of pregnancy and maternity care in universal health care or subsidize provision of these treatments and medicines to ensure that they are affordable;**

(g) **Restrict conscientious objection to the direct provider of the medical intervention and allow conscientious objection only where an alternative can be found for the patient to access treatment within the time needed for performance of the procedure;**

(h) **Exercise due diligence to ensure that the diverse actors and corporate and individual health providers who provide health services or produce medications do so in a non-discriminatory way and establish guidelines for the equal treatment of women patients under their codes of conduct;**

(i) **Provide age-appropriate, comprehensive and inclusive sexuality education based on scientific evidence and human rights, for girls and boys, as part of the mandatory school programmes. Sexuality education should give particular attention to gender equality, sexuality, relationships, gender identity, including non-**

conforming gender identities, and responsible parenthood and sexual behaviour to prevent early pregnancies and sexually transmitted infections;

(j) Ensure that the standards contained in the present recommendations are observed and enforced by all health-care providers, public or private, and engage both women and men, as appropriate, in efforts to prevent discrimination, stereotyping and instrumentalization of women's bodies and biological functions.